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AUTHOR Mehr, Joseph
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ABSTRACT

From July, 1974 to June, 1977, a federally funded project to develop a competency based training program for human service workers was run at Elgin Mental Health Center, a 750-bed inpatient, state psychiatric facility. During the course of the project, over 500 discrete tasks were identified which such workers perform. Tasks were grouped into functional modules and competency (performance based) criteria were developed. A major effort of the project was to develop a training design using these modules, which could be integrated into an existing career ladder. By the end of the project, this objective was accomplished and an evaluation of the project was completed. The evaluation indicated the effectiveness of a competency based approach in delivering training to human service workers. (Author)

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TASK ANALYSIS AND COMPETENCY BASED TRAINING

THE ELGIN MODEL

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Joseph Mehr, Ph. D.
Chief Psychologist/Director
Intensive Behavior Therapy Program
Elgin Mental Health Center
Elgin, Illinois 60120

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BACKGROUND OF THE PROJECT

Why did a government agency, seeking to develop competency-based education, find a willing partner in the form of a large state mental institution, seeking to bring vast changes about in therapy and treatment. The answer is an odd, almost coincidental overlapping of common interests.

The government agency--HEW's Fund for the Improvement of Post-secondary Education--had already approved 19 other grants to underwrite competency-based educational research for FY 1975, mostly to academic institutions hoping to bring about significant changes within traditional academic settings. The 20th grant, which Fund officials later confessed was a "high-risk, high-gain" decision, was something of a wager on the notion that if competency-based education was as universal a concept as it was believed, then a true test of its applicability would be in a work setting--not a learning setting. What greater proof could exist if the concept proved workable in a large, complex mental health system?

The mental health system that was chosen was hardly a typical one. The foment and changes that had already taken place at Elgin Mental Health Center near Chicago, Illinois were creating ripples in the mental health field. A number of coveted theories and traditiional thinking had already been discarded by two of EMHC's administrators, Walter Fisher and Joseph Mehr. Well-documented in

their co-authored books on this subject (with Philip Truckenbrod), Power, Greed and Stupidity in the Mental Health Racket and Human Services: The Third Revolution in Mental Health, their efforts centered on dealing with the here-and-now behavior of patients, not on the medical model of institutional care that sought "cures" for mental "illness." Beyond the development of an operating model of new therapeutic concepts for the institution, Mehr and Fisher were also active in remolding the institution's organization of manpower resources to assure success in the new concepts. Generalist "teams" of multidisciplinary "Human Service Workers" replaced custodial-care Aides. Team Leaders were chosen and assigned. Teams functioned on 13-hour therapy days and each team member carried a patient caseload. Decentralized decision-making began taking place at the Team (ward) level and new levels of responsibility accompanied the new job titles. Most important, the new methodologies and new organization showed signs of working: an extended care program began discharging patients who responded favorably to the new treatment model. Discharges throughout the hospital increased. Staff morale soared.

Moreover, a spiritual quality, almost a mystique, arose from the dynamic interaction and sharing of responsibility taking place on Elgin's new ward-based teams. A hard-to-define quality emerged in the profile of an effective team member. Effective team members were the problem-solvers, the confident workers, those with empathy and tolerance and indefatigable resources. Fisher and Mehr found that traditional academic disciplines--psychology, sociology, psychiatry, nursing--often did not supply these factors. The best workers on

the teams were often those not necessarily exposed to the classic mental health disciplines, but those who instead had vastly different backgrounds. So, out of the change grew new complexities, new uncertainties. "Sometimes," one staff member remarked, "I yearn for a simple task like chopping down a tree. It is well-defined. It has a beginning, a middle and an end. Even in its simplicity, there is something satisfying about it that is absent in the subjectivity and complexity of mental health work."

Chopping down a tree--a task that has a beginning, a middle, and an end. And what are the tasks in mental health work? What tasks constitute the work of an effective generalist in a dynamic team setting? What competencies do we look for if traditional disciplines cannot relevantly prepare manpower for these new, challenging jobs?

Elgin Mental Health Center had courted the notion of competencies for its mental health workers for several years before receiving a grant from the Fund. A "Core-Competence Training Manual" attempted to nail down the basic knowledge any mental health worker would need to know in order to function competently at the team level. But inside the covers was a training outline and curriculum developed along classic, traditional educational methodologies.

Fortunately, our efforts coincided with FIPSE's need for a competency-based education grant to a non-academic institution. Moreover, there were some strongly-based needs which we sensed at

Elgin Mental Health Center that the establishment of true competencies could fulfill. Among these needs:

1. Removing the "mystique" from mental health needs -- There remained a strong need to nail down precise competencies that made a team-based mental health worker something unique among traditional institutional programs.

2. Establishing a more satisfying objectivity to an up-to-now subjective field -- Mental health has been filled with "faddish" medical-model attempts at mental illness cures--electroshock treatment, insulin shock, massive sedation and use of psychotropic drugs. In the switch to a positive behavioral model of therapy, some of the procedural, step-by-step objectivity that these previous treatments lacked began to be developed.

3. Getting control of team management -- Diffuse "generalist" job roles and "do-everything" team members proved no easy match for team leaders, who needed objective job assessment techniques to effectively manage their wards and assure employee promotions when they were deserved or warranted.

4. Giving academic credit for known skills and competencies -- Employees without traditional academic credentials were trapped in the Illinois system when the new mental health career ladder was adopted. They were promoted beyond their credentials and could not leave for other systems. Could

proven proficiencies in special mental health functions be equated to hours in a classroom memorizing facts about treatment?

5. Relinking employees with the educational network -- Many employees yearned to return to school to attain GED's, undergraduate degrees and graduate degrees. But even bringing credit-bearing inservice training to the hospital, as Fisher and Mehr did, did not fully satisfy the need to relink more employees to the educational network.

6. Allowing changes to emerge at ward levels to impact hospital-wide goals and objectives -- The energy and drive of new generalists on the ward-based teams could exist as long as the effects of their work made a visible impact on the system as a whole. How could the viable changes occurring at the ward level effervesce and emerge at the "top" to make a significant impact on hospital-wide goals and objectives?

7. Establishing an in-house capability for implementation of a competency model -- Finally, and perhaps most importantly, the need for developing an in-house capability to perform needed change was sensed. Could hospital workers, training staff, team leaders or others develop a methodology for converting to a competency-based system of training and assessment?

In short, a competency-based education model at Elgin Mental Health Center would answer a great many pressing needs. More important, it would provide a detailed "snapshot" of an intuitively successful change-over of treatment methodologies and organizational strategies that could constitute a baseline for further changes and development. For once, the ingredients in the successful Elgin mixture could be isolated, identified, and labeled. Knowing this, team leaders could function more effectively on their jobs. Mental health workers could enjoy precise expectations in terms of work output. Goal-oriented assessment criteria would be applied to all employees. Other institutions seeking to emulate Elgin's successful conversion could be supplied with the methodology to achieve that change in their own settings.

And perhaps, competencies could be extended to community mental health clinics and outreach workers. Perhaps to the clients themselves--observable behaviors that signal their progress toward discharge and return to normal, productive lives in their communities. Might not these also constitute competencies--coping competencies?

In March of 1974, a complete grant proposal for a competency model program for Elgin was submitted to the Fund. Modifications were made, mostly in details regarding program staging and budgeting. By late June, the award was announced. FIPSE would underwrite a three-year, $314,000 effort at Elgin to identify mental health worker competencies and to write training curriculums based on these competencies. Work would start July 1, 1974.

To the project staff, Mehr and Fisher now addressed a new set of challenges and mandates in carrying out the grant. Outlining "operational strategies," they agreed that the staff should manage and administer the grant in such a way as would:

1. Build in a lasting "vehicle for change" into the hospital so the impact of the grant might continue long after the government terminates its support.

2. Identify a "new leadership" among middle-level hospital manpower -- The project should tap a new, second-generation source of leadership from among middle-level management within the hospital.

3. Reawaken enthusiasm for the operating model -- The program should be undertaken in a manner and style as to reawaken a new level of enthusiasm for the treatment model at Elgin Mental Health Center and in Elgin's team-based organizational innovations.

4. Meet the real, day-to-day needs and interest of the participants -- The program should in some way identify and then strive to meet the real, pressing needs of those enjoined to participate in it within the hospital. It must address itself to problems and concerns that the system has generated to date.

5. Improve service delivery -- The program must fundamentally seek to improve the delivery of mental health services to the consumer. It must adhere to goal-oriented, client-centered treatment modalities.

6. Produce needed output for competency-based curriculums and training -- Of course, the program must satisfy its own stated goals of producing competency-based curriculums for mental health workers. Specifically, this called for:
   a. A list of mental health worker tasks
   b. Component elements in those tasks
   c. Skills needed to carry out the tasks
   d. Competencies derived from the component skills and tasks
   e. Assessment criteria for the competencies
   f. Guidelines to implement a competency-based training program within the hospital.

7. Lay the groundwork for later implementation -- The program must establish a "benevolent environment" for later implementation, wiping away possible threats and impediments to its success within the hospital. An "acceptable environment" must be created.

8. Train the trainers -- Staff Development functions at the hospital must be retooled to deal with competency-based learning and assessment techniques and methodology. The

trainers must, themselves, be re-trained in the new competency-based technology.

Already, a methodology to achieve these aims had been suggested: In the Spring of 1974, while final work was still underway on the proposal to be submitted to the Fund, an accredited college course was offered at the hospital on "Competency Module Development." Attended by a key group of team leaders, program coordinators and training staff, the course was taught by the same consultants who drafted the original FIPSE proposal. Operating for a full semester, the course examined the concept of competencies, surveyed the task analysis process and involved students in the actual development of competency modules using a deductive model based on Joint Commission on Accreditation of Hospitals' Standards.

This course provided a manpower nucleus for an important program strategy once the Fund awarded the grant. The strategy: organize a new accredited course designed to meet the participants' needs while at the same time producing program output in the form of task analysis, competencies and evaluative criteria. The previous spring's course also generated a wealth of "feedback" and information that was an intimate part in planning the new course.

Called "Task Analysis -- Tool for Managerial Effectiveness," the course was designed and taught by two consultants experienced in both competency-module development and in college-level instruction. These two consultants--who were about the same age as most employees

participating in the course--also had an impressive track record of work in the area of strategies for change within organizational settings. By combining constant interface with real-life situations through consulting along with their programs of doctoral studies at Vanderbilt University's Graduate School of Management, they constituted a rare blend of theory and practice. The program appeared to them as an exciting challenge.

Students for this new "Task Analysis course enrolled in response to a course design carefully prepared by the instructors to demonstrate how the course would address their everyday needs and how their participation would enhance their effectiveness on their jobs. Publicity for the course was also provided by the hospital's weekly "Newssheet"--both consultants composing a promotional "squib" about the soon-to-start course. Direct calls from the CHP staff to potential students were made to enjoin their support. Packets of course material, resumes of the instructors and personal letters were sent to twenty selected employees, mostly team leaders. The hospital's Staff Development Department coordinated the logistics, signing interested employees up, arranging for a classroom, and answering questions from employees about the course.

Classes commenced, and the employees attending the course turned out to be--for the most part--ones who had not participated in last spring's course. These were people new to the concept, wary and skeptical but interested enough to rearrange their daily priorities and arrange for proper ward coverage to allow them three hours each week to participate in this new idea.

UNDERLYING ASSUMPTIONS AND PROJECT BACKGROUND

The focus of the Elgin Competency Model program is a large state mental institution which itself has undergone drastic change over the years. Important to an understanding of program strategies and operations is a grasp of some of the assumptions the project staff made regarding the model and its environment:

1. The Personnel System at the hospital was advanced compared with similar institutions. The classic medical model and professionalistic departmental structures had been succeeded by generalist "teams" of employees operating with great autonomy on the wards, carrying out imaginative therapeutic programs. The hospital has documented evidence demonstrating the increased effectiveness of the Human Service Generalist model and a formal Career Ladder was instituted through the Illinois Department of Mental Health to institutionalize these new job functions.

2. Nonetheless, there was a clear notion at the hospital that serious deficiencies existed in the current system, particularly in the areas of:
   a. Staff development and training
   b. Personnel system
   c. Task allocation.

Administrators expressed feelings of dissatisfaction, powerlessness and a separation of function from ward-based personnel. Team leaders and practitioners complained of problems in employee competence, tardiness and coverage. Attention to "custodial" and maintenance functions, such as ward cleanliness, seemed to divert attention from positive therapeutic programs aimed at resident discharge. Staff training seemed to bear little relevance to actual employee needs for upgrading.

3. Hospital employees would not participate meaningfully in the Elgin Competency Model program unless they could perceive clearcut "payoffs" for themselves or their immediate organizational units as a direct result of their input into the project. Already taxed and overburdened, prospective participants in the program were crisis-oriented to pressing daily needs in their normal work situations.

4. The support and legitimization of hospital management was essential to the program's success and later incorporation into ongoing hospital programs and objectives. Any attempt to restructure or change training and manpower development would necessarily have to earn the endorsement of important, key management officials of the institution.

5. Hospital management would respond more positively to visible program outputs than to conceptual designs and predications presented hypothetically. Not only would evidence of previous

work input create an obligation on the part of managers to lend their attention to the program, but managers' response would be more easily structured along lines of concurrance and co-opting rather than a relationship of dependence for substantive, cognitive input.

6. Changes brought about by the model would have to be perceived as a logical, contiguous extension of existing hospital policies and procedures in order to become acceptable. Radical departures from agreed norms would not be tolerated by the institution, nor could managers accept implicit condemnation of past decisions as a proviso for implementing new innovations.

7. Any attempt to impact training delivery while neglecting supervision and management policies and procedures was doomed to failure. Without reinforcing behaviors on the part of supervisors and decision-making authorities in the institution, change "effervescing" from the ranks would be quelled as rebellious and organizationally disruptive.

8. Any change wrought as a result of the program would have to be perceived by the hospital staff as <u>their</u> change in order that the model be perpetuated beyond the period of the grant. A commitment to the program and a true feeling of ownership of the components leading to its implementation would have to be felt throughout the hospital.

9. Work inputs to the program by hospital personnel had to be volitional and voluntary--hired or conscripted help doomed the model. A coercive intervention into the system would ultimately produce counterproductive retaliation by staff, and work rewarded by grant money would cease when funds stopped.

10. Meaningful change in the institution must emanate from a level closest to the area of implementation--viz, ward-based teams in the Elgin setting. Already committed to semi-autonomous operation of generalist teams, the decentralized structure of the hospital demanded that full attention must be given practitioners at the ward level.

11. A solid base of reliable, authentic data generated by hospital practitioners was a necessary ingredient to substantiate any later decisions made to develop a competency-based training system in the institution. A rock-solid foundation of well-founded, factual and incontrovertible evidence was needed to support recommendations to alter the system to accommodate the new program.

12. There was an ambiguous, vague nature of job roles in the institution designated for competency-based training. Do-everything "generalists" defied definition and job descriptions embraced wide spectrums of possible activities. The departure of disciplinary professional norms from the generalist model led to interdisciplinary confusion on specific expectations of job performance.

13. The result of the program would have a significant hospital-wide impact on job roles, manpower, utilization, work allocation, training of employees and on service delivery. It would have secondary impact on grievance handling, employee discipline and turnover, absenteeism and assessing employee performance uniformly.

14. Any competency-based education model developed in response to Elgin Mental Health Center needs and problems would need later modification to achieve recognition by postsecondary educational institutions who could credentialize competence in degree-bound programs. The interfacing of a traditional institutional time-based learning program with a proficiency-based worksite program would call for substantial "bridging" to achieve full integration.

RESULTING PROGRAM IMPERATIVES

Stemming from the background assumptions coloring the introduction of the model at Elgin Mental Health Center are certain program imperatives or theoretical underpinnings of the model that were to guide it in its operations and planning stages. These are:

1. A working definition of competence which, for purposes of this program, was:

   "The ability to perform a task to some level of internally or externally-imposed criteria, as stipulated in the training objectives."

2. All the tasks constituting the employee's job must be somehow identified and the resulting list of tasks will represent the full spectrum of observable job behaviors of the target population of the hospital.

3. The resulting task analysis will constitute an amorphous compendium of tasks ranging from the most menial to the most sophisticated, crossing skill and job function areas.

4. Tasks identified must be validated for reliability in a field setting by dispassionate, objective and knowledgeable practitioners before becoming incorporated into training and management models.

5. The organization of identified tasks must acknowledge functional job roles within the hospital structure if they

are to be incorporated into training and management models.

6. Training must take place addressing needs of functional job areas, and must be predicated on individual trainee's need and ability to successfully perform tasks required by his/her job role.

7. The partnership between management and training must be meaningful and strong insofar as training prepares staff to perform tasks explicitly identified by management in such a way as to enable management to evaluate accurately an individual's ability to perform the requisite task.

8. Training must be related to tasks that the staff performs or will perform, and it is incumbent on management to prepare staff to assume new competencies while monitoring employees' performance in their current set of tasks.

9. Just as there are clear-cut tasks for employees, there is also a set of clear-cut tasks and competencies for hospital management, including ward-based team leaders, other middle-level management and training personnel and top administrators of the institution.

10. To implement the program, classic organization behavior models may be introduced if they lend themselves to the modifications and assimilation needed to accommodate the unique demands and needs of the project and its setting.

11. Overall implementation strategy must employ a synergistic process model creating a system of interacting processes that could survive independently but would reinforce one another to achieve the program's objectives and goals. In a large institution stratified by traditional hierarchy, a "meiosis" of ripple-effect change is needed to create a successful symbiosis of systems interacting for the mutual good.

ESTABLISHING OPERATING MODELS

The program imperatives or theoretical underpinnings gave cause to establish specific operating models to govern program strategies and decision-making. These models acknowledged important assumptions regarding the program's setting and its "host environment," and acted upon the imperatives deemed necessary to implement the program successfully in this context:

1. The Participative Model - Questions of project "ownership" are addressed by obtaining a high level of participation from hospital employees in carrying out the project's objectives. Adopting a participative model also assures knowledgeable project input from practitioners close to the level of impact of the ultimate training efforts, and precludes a deductive, coercive model of prescribing change for subordinate levels which would be met with resistance and eventually suffer sabotage from subordinate ranks. The project staff agreed that a participative model would be a preferred approach for implementing this project.

2. A Functional, Task Analysis Model - A reliable data base was needed to identify appropriate competencies and no current task analysis information was available from the hospital. Therefore, the project set about compiling its own data base, utilizing hospital employees to generate a task analysis and conduct reliability checks on tasks identified for the hospital. By adopting a functional approach, all participants learned

simultaneously of the real needs to be addressed by a competency-based training program and felt a true sense of involvement and ownership in the findings revealed by this important research phase. The fact that such data did not previously exist gave added value to its development and earned the rapt attention of administrators who were understandably curious about how, by whom and where tasks were being carried out at the ward levels of the hospital.

3. Coursework/Task Force Methodology - Consistent with the assumption that clear "payoffs" must exist for project participants providing input into the project, we organized a coursework model that awarded college credit at Northeastern Illinois University for employees enrolling in courses designed to generate task analysis and competency outputs. At the same time, the project adopted a model of organizing "Task Forces" of select employees to concentrate on discrete work assignments in a non-organizational setting, temporarily disaffiliating themselves from status, rank and institutional loyalties to approach synergistically specific challenges brought to them by project staff and consultants. Membership in task forces was voluntary and solicited by personal invitation, whereas membership in accredited courses connected with project output was open and advertised in a hospital newssheet.

Coursework methodology was developed to address real needs of participants voiced in the class and demonstrated how the Competency Model could address such needs. Considerable

coursework software was generated for the courses offered and constituted pre-curricular development for later competencies to emanate from the groups. The adoption of these methodologies enabled the project to build a growing retinue of "believers" and participants owning a piece of the project, and the composition of any task force could be manipulated to provide expertise and input from the most promising sources. Task force and coursework work allocations were made along guidelines of following individual participant's energies and interests. Competency concepts of mutual accountability, negotiated outputs and contracted behavior were instituted in each task force and coursework setting to illustrate the approach in a way meaningful and germane.

5. Management Model - During the first year a "Management Model" of administrative considerations regarding the competency-based training model emerged from the work of the project. It became clear that managers (including middle-level team leader management) would be instrumental in assessing employee competence, allocating tasks to employees, holding employees accountable for certain competencies and negotiating with employees for training to remediate or initiate competency in specified areas. A competency-based management approach was developed for a special seven session, 21-nour Management Seminar for hospital administrators that resulted in the identification of management competencies and an Administrator Curriculum .

Managers were trained to adopt competent behaviors in their own jobs to stimulate competency among subordinates, and were provided tools to accomplish this in the form of a complete coursework notebook containing a number of modules, each divided into:

a. Introduction
b. Behavioral objectives
c. Training experience
d. Lecturette
e. Vocabulary sheet
f. Additional readings
g. Worksheet
h. Assessment methodology.

Preparing administrators for a competency-based model was another way of laying important groundwork for the program's implementation in the hospital.

6. Tentative Working Model for Training Program - Only weeks after the program began, a plan was drafted for a tentative working model of a training program. A conceptual matrix was created that differentiated identified tasks by job classification and divided all tasks into three discrete areas:
   a. "Key" or "critical" competencies constituting a core curriculum for any given job classification level.
   b. "Promotional" or "touchstone" competencies constituting a core for the next higher job level.

c. "Loose leaf" modules of competencies introduced for any job classification level depending on specific job functions at that level.

Later, as task analysis yielded several hundred validated tasks observed in field settings, discrete functional areas were established to offer a gross organizational framework for temporary "slotting" of tasks. The functional areas included:

Resident Care

Maintenance

Administration/Supervision

Clerical Work

Casework

Community Placement Service

Liaison and Transportation

Safety and Security

Public Relations

Vocational Rehabilitation (Ward Workshop)

Social and Recreational

Nursing Care

Training.

Two more categories or functional areas were later added:

Teamwork

Behavioral Therapy.

Organized under these 15 categories, 508 discrete tasks were reviewed by 300 respondents in a special project survey

who, by indicating which tasks they actually perform in work settings, enabled a classification-by-classification breakout of tasks to occur. This "task slotting" provided the project and hospital managers with a clearer picture of how task allocation was currently handled on hospital wards. Meanwhile, special Staff Development task forces identified nine generic skill areas extant in the competencies developed in the program and isolated some 90 training objectives, under which groups of competencies subscribing to the same objective were clustered. The scrutinization of competencies afforded by these exercises led to the development of still more functional areas as follows:

Resident Assessment

Basic Therapeutic Interaction

Crisis Intervention

Counseling

Finally, tasks within the 19 functional areas were sub-modularized into smaller groupings in preparation for allocation to specific job roles by special action of the hospital's Executive Committee, who deemed the project's data important enough to convoke a hospital-wide seminar to review employee job roles and develop clearer expectations in light of competencies now available. "Clearer expectations" will be core groups of "critical competencies" required of any given job level by hospital management. Staff Development personnel will train "critical competency" core groups along

with other selected competency submodules, replacing time-based training requirements for promotion with the new performance-based competency model.

7. Consultant Utilization Model - Considerable responsibility was borne by selected project consultants who designed and carried out coursework, contributed program strategies and organized and led task forces. Following the model being introduced, specific consultant work outputs were identified at the outset of the relationship and deadlines for submission of each output were negotiated. Incremental work output submissions and accordant deadlines were likewise negotiated when outputs were particularly complex or intricately serialized. Consultants demonstrated full accountability for their time by completing "Consultant Work Output Logs" indicating activities and outputs for each day billed. Finally, pursuant to an effective "transfer of ownership" of the model from the Center to the hospital, consultants were phased out of the program and major responsibility shifted to hospital personnel who, by then, had developed sufficient expertise and knowledge to provide effective leadership and guidance to the program. The Center staff provided key linkage and guidance in a low-key manner to ease the transition in "de-consultantizing" the project.

PROJECT OUTCOMES

After three years of effort, the grant-supported phase of the project is complete. It has accomplished a number of its original objectives, but of course, in such a program, one is never finished. The concrete accomplishments are as follows:

1. A complete task analysis of all levels of the Illinois Career Series, yielding 508 distinct tasks (See Figure I for sample tasks).

2. The grouping of tasks into 14 task units based on function similarity.

3. The development of 27 training modules, each with a behavioral pre and post assessment technique, syllabus, methodology, and training aids, including video tapes, simulations, graphics, and handout materials (See Figure 2 for sample page).

4. The "slotting" of task units and modules into the Career Series. In effect, the creation of task specific job descriptions and training requirements accepted by the Illinois Department of Personnel (See Figure 3).

5. Implementations of pilot training programs to test modules, with the result of establishing proficiency criteria, pass through criteria, and the effectiveness of the training: 80% successful completion upon first experience; 99% successful upon first repetition.

6. Implementation of ward setting evaluations which reveal that module trained employees are able to complete required tasks more acceptably than those trained in the traditional methodology.

7. Establishment of the competency-module system as the formal training program of Elgin Mental Health Center, a 720-bed inpatient facility with 1100 staff.

The project has, of course, not been entirely successful. The major problem is that the notion of competency-based management, while fully accepted by most unit (team) directors, has had little impact on higher management (e.g., the superintendent, major program directors, etc.) even while they strongly support it for the unit level. The second problem is that the project bit off a bit more than it could chew: during the life of the grant, a number of staff activities were not task analyzed due to time, money and manpower restraints. These areas include such things as group work, group psychotherapy, and individual counseling. To completely task analyze all activities might well take ten years, a monumental "task." To be sure, however, the task analysis is a currently ongoing process as it must be in any changing institution. The major question remaining is how long the resources will be available to continue the development of new modules.

IMPLICATIONS

The introduction of task analysis at the ward level presents various possibilities for change, depending on the willingness of higher level decision makers to participate in the experiment. The change can be limited to the ward (between a team leader and his team members), can be inter-departmental (between a ward and the training unit), can be inter-level (between a ward and a program), or can be global (institutional goal setting). Task analysis is a change-laden intervention because it makes explicit the patterns of activity which occur within the basic organizational unit of a mental health hospital. Task analysis is the inverse process of systems analysis which starts with the system objective and works backwards to define the ideal set of activities required to accomplish the objective. Task analysis starts with what people actually do and asks the following questions:

(1) What performance standards should be established for these tasks

(2) Are these all the tasks that we'd like to see performed

(3) If both the actual and the desired tasks were performed at the prescribed level of performance what objective are we achieving

The task analyst, once having answered these questions, can compare the outcomes which are being accomplished with the set of ideal objectives the system would like to achieve. Gaps can be addressed by introducing or deleting tasks, changing performance standards or changing system objectives.

Changes which are limited to the ward concern principally the relationship between the team leader and his team members. The team leader who can explicitly identify all the tasks required to meet ward goals can better organize his resources for effective task performance. Team leaders can

match tasks to abilities, personal dispositions, and available manpower by possessing a check list of all the tasks which must be performed. At the same time, the team leader can use his understanding of task requirements to set contracts with individual members of the team and hold them accountable to explicitly defined performance criteria. Finally,teams are effective when team members know how what they do relates to the overall goal of the unit. Task analysis, then, provides a detailed map of unit activities so that team members can see precisely how their individual efforts contribute to the total set of activities. This same map is also helpful in translating the generalist concept into concrete terms for wards which have recently introduced the generalist model. The team leader can use the task chart to indicate how the functional arrangement will be modified, referring to specific tasks rather than describing the change in abstract, theoretical terms.

Task analysis provides an ideal interface between the ward and the training/staff development unit of the organization. One of the recurrent problems in mental health institutions is that the training programs do not always correspond to the actual activities which must be performed by technicians. Communication channels which exist between the ward and the training unit are not capable of transferring the amount of information required to tailor training programs to specific needs. Because task analysis is based on what people perform to get the job done, it is a vehicle for transferring job-related information from the ward to the training unit. The ward team leader identifies the functions and the tasks which technicians perform on his ward, the training coordinators pulls the corresponding task analysis charts and tailors a training program for the ward's specific needs. The mechanism for communicating training needs to training is a check list of tasks which are relevant to ward performance.

This checklist is filled out on a periodic basis by the team leader and routed to training. The team leader can also use the checklist to jointly plan a professional development strategy for the technician.

Task analysis can also be used to initiate, develop, execute and evaluate resident programs which cut across departmental boundaries or span several levels in the organization. Task analysis forces the program analyst to operationalized concepts by specifying the mix of activities which will promote the program objective. When tasks are clearly identified coordination among units becomes an open process of rational allocation rather than a closed political process of power and influence. Units which are best equipped to deal with specific tasks are chosen to implement a given aspect of the program. Because the behavior is concretely described, program evaluation, at one level, becomes the process of measuring the frequency and the quality of the behavior incidence. Task analysis technology provides a framework for testing assumptions about the treatment model. An underlying assumption of ward organization for program effectiveness is that the particular mix and sequence of activities currently utilized is the best one for achieving program goals and objectives. Task analysis makes the treatment model explicit so that variables may be manipulated in the interest of improving program performance.

Finally, task analysis provides the institution with a mechanism for assessing organization-wide performance, the most powerful application of this technology. Instead of dealing with organization goals and objectives which are often vague, general and hard to operationalize, task analysis takes a micro-perspective of organization performance. Task analysis assumes that for any desired outcome there is a sequence of activities which are relevant for the accomplishment of the outcome. If the outcome

is resident care, the task analyst will attempt to identify the activities relevant for resident care which are currently being performed. The organization can then determine if the current set of activities is appropriate, in quality or quantity, to meet the desired outcome. If not, the decision-making structure can quickly pinpoint the factors (missing tasks or tasks performed at an unsatisfactory level) for modifying the situation. In this sense, task analysis deals directly with issues raised by the Joint Commission on Accreditation of Hospitals. The JCAH is becoming increasingly sophisticated in measuring adherence to minimum standards. In many respects, however, task analysis is far ahead of the JCAH state-of-the-art, by specifying identifiable behaviors and performace criteria for these behaviors.

The introduction of task analysis technology, as one can see from the preceding discussion, has implications for change at several levels within an institution. The minimum level of change is the self-contained ward. The task analysis can be performed by or for the team leader and may be focused entirely on the relationship between the team leader and the team members. Task analysis can be used to integrate the formal training function with ward activities and therefore involves change of an inter-departmental nature. Change at this level occurs only when both units see how their individual self-interests can be met by task analysis-based cooperation. Third, program coordination can be improved by applying task analysis to programs which include several wards and thus require tighter integration, feedback and instream evaluation. Fourth, task analysis technology can be applied to the goal setting and policy formulation processes of an organization by asking key questions concerning current activities and desired future outcomes. The determination of

of what levels change derived from applying task analysis technology will occur is a function of the investment top level decision makers are willing to commit to discovering really how their organization goes about its way.

VI. Casework (continued) FIGURE I

C. Treatment Planning and Documentation

132. Recommending therapeutic intervention (i.e., pulling passes, giving passes, phone calls)
133. Writing programs for residents
134. Helping to implement programs and arrange for feedback
139. Scheduling resident for special groups (resocialization, pre-discharge)
147. Writing progress notes
148. Writing 72 hour, 14 day and 30 day treatment plans
162. Attending clinical meetings
179. Referring resident to Clinical Advisory Board
-- Restricting relatives from visiting
-- Documenting restriction

D. Handling Legal Problems

168. Ascertaining and clarifying legal status of resident (conservators, civil rights, etc.)
169. Handling special criminal/civil legal problems
-- Handling special financial problems (estates, non-payment of care and maintainence changes, DMH/DD suits against estates, etc.)

E. Dealing with Residents' Social and Personal Needs

25. Writing letters for residents
26. Reading mail to residents
102. Distributing mail
104. Recording resident phone calls
154. Meeting with residents on a regular basis to discuss their progress and future planning
155. Sending telegrams to relatives
156. Maintaining contact with those who have an investment in resident--relatives, friends, etc.
157. Fulfilling material needs of residents via calls to their relatives
158. Coordinating visits of family and friends with treatment program
175. Ordering needed clothing, glasses, false teeth, etc.
178. Writing trust fund slips
374. Arranging areas for family visits
394. Communicating with relatives about resident's medical status
395. Communicating with resident about his/her medical status

F. Discharge Planning, Workup and Completion

137. Planning placement activities
138. Assisting in the tracing of resident citizenship of naturalization papers
146. Preparing referral forms
149. Filling out Veterans Administration forms
151. Filling out social security forms
152. Preparing pre-discharge forms such as public aid, social security, pension, etc.
163. Corresponding for referral material, etc.
164. Ascertaining resident readiness for discharge
165. Ascertaining appropriateness of transfer
166. Preparing resident's personal effects, clothing, etc.
167. Ascertaining financial status of resident
170. Orienting resident to discharge or transfer

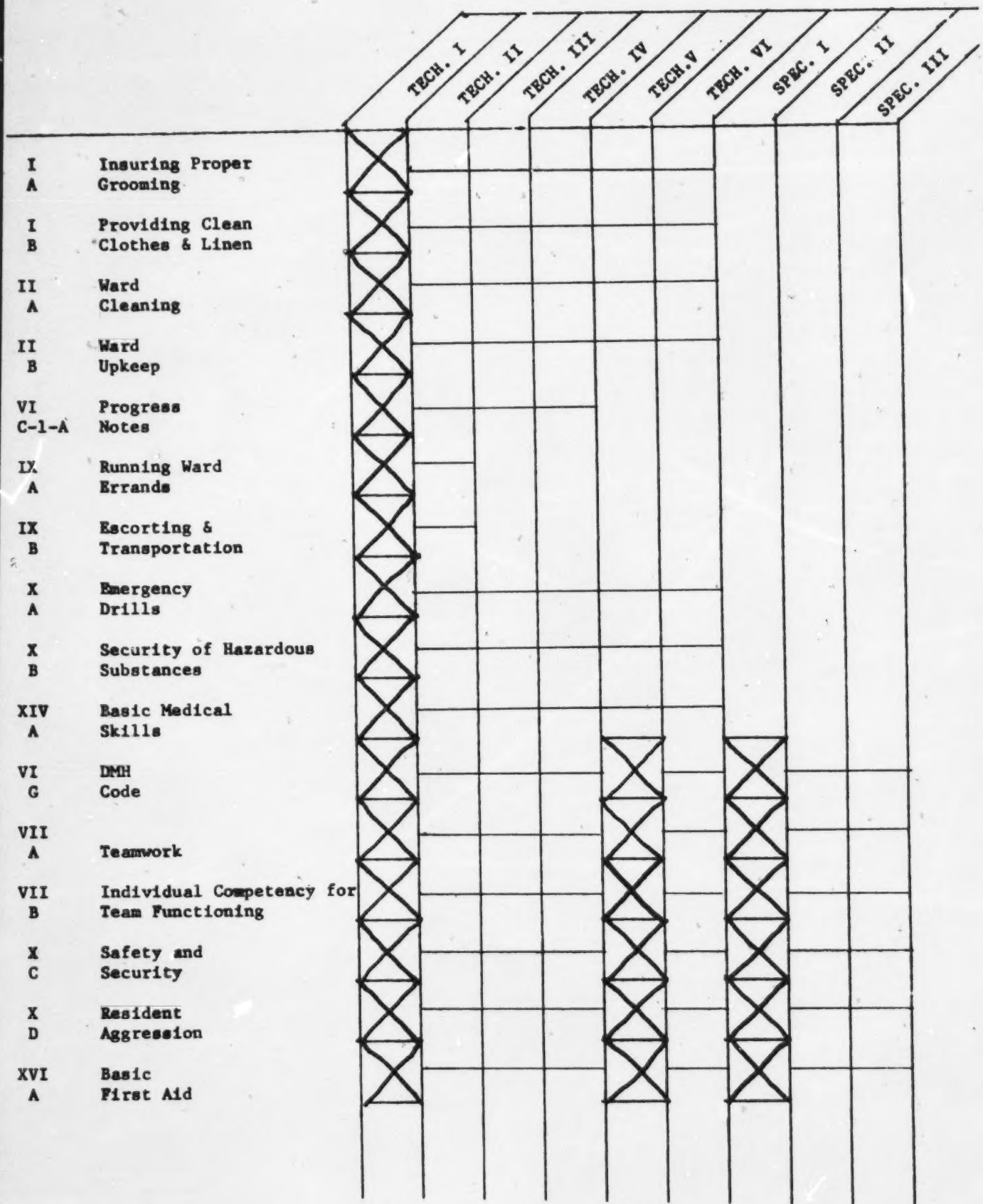
MODULE I: IDENTIFICATION AND DEFINITION OF BEHAVIOR, AND IMPLEMENTATION OF BASELINING

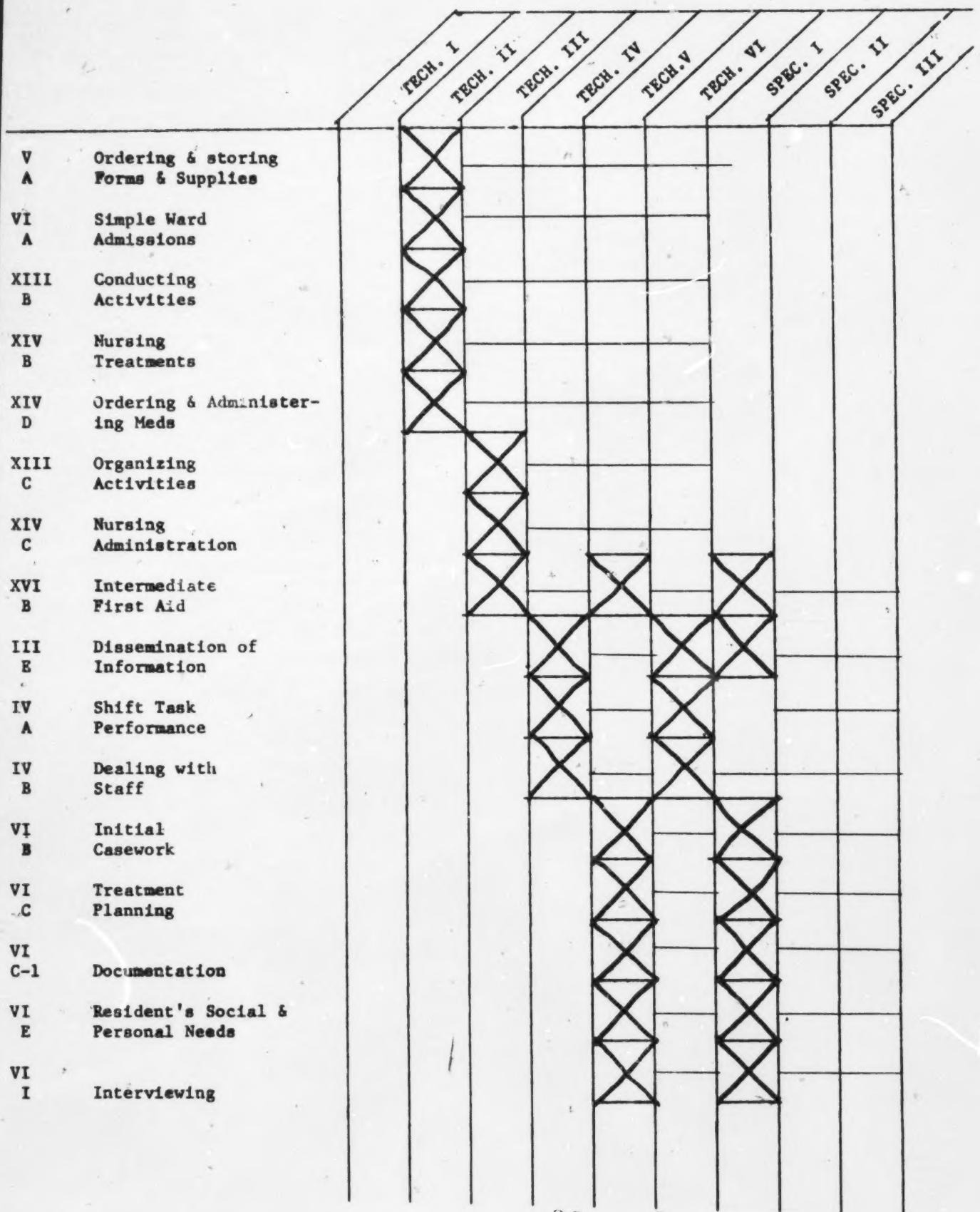
MODULE OUTLINE	METHODOLOGY	RESOURCES
Day 1		
Behavioral - anything a dead man can't do overt - observable, measurable; can be perceived by the senses. Example - walking covert - not observable. Example - thinking	short lecture/discussion	Handouts: criteria for discharge Behavior techniques article
I. Determine a Problem Behavior		
A. Behaviors dysfunctional in current or target environment B. Behaviors which will not be reinforced in current or target environment C. Behaviors whcih will be punished in current or target environment		
II. Put Problem Behaviors into Hierarchy Reflecting Frequency or Severity	lecture/discussion	
A. List behaviors from the most maladaptive to the least maladaptive		
III. Determine Target Behavior	lecutre/discussion	
A. Target behavior is the alternative behavior you want to teach to the person		
IV. Define Problem and Target Behaviors stipulating where applicable	lecture/discussion; in-class exercise	In-class exercise #1
A. Frequency - number of occurrences of response B. Latency - duration of time passing between onset of stimulus and occurrence of response C. Duration - length of time passing between onset of response and end of response D. Intensity - strength with which response occurs E. Accuracy - percent of responses that are correct		
	home learning assignment	read Schaefer & Martin, pp. 65-69 and the outline of the various data sheets

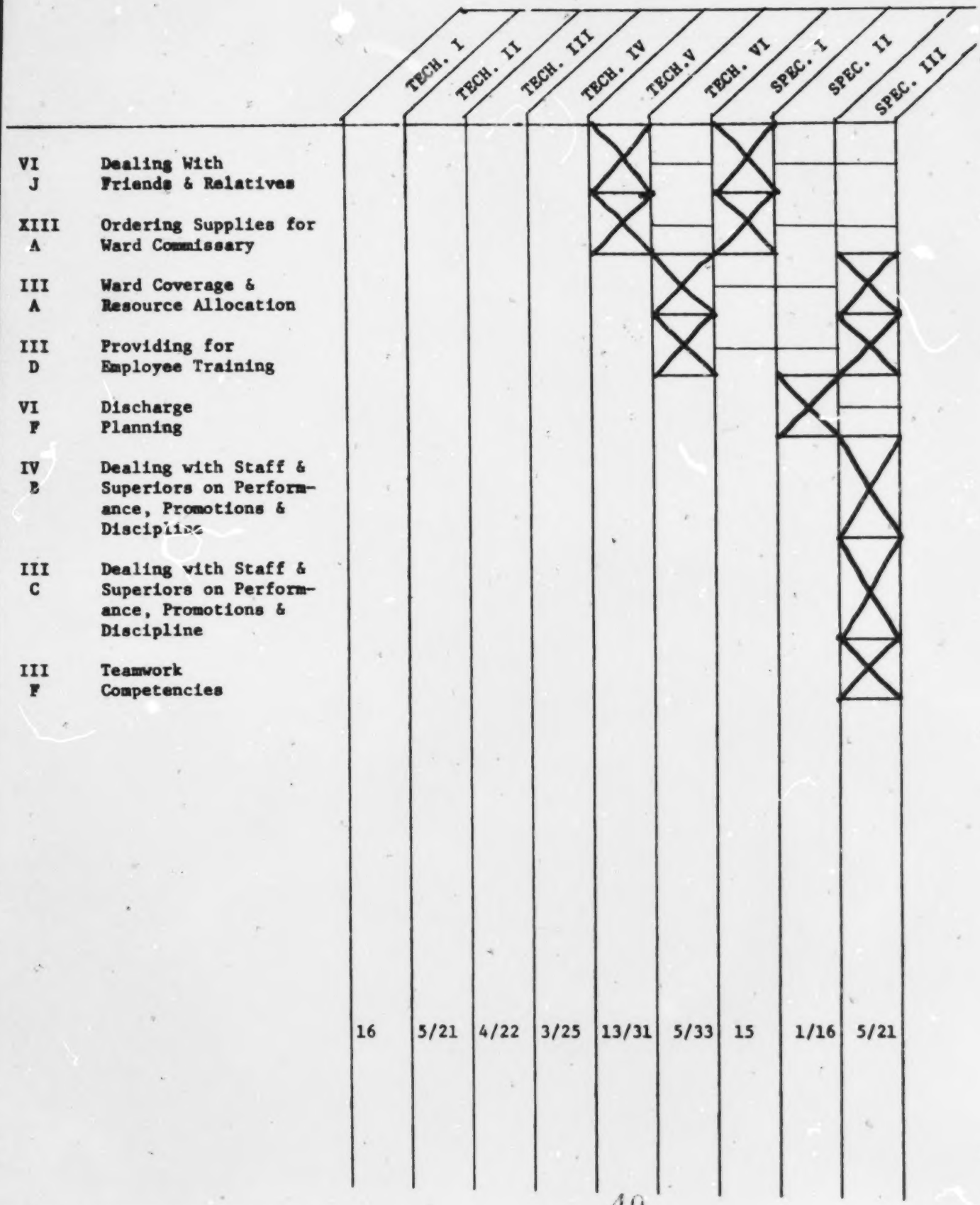
FIGURE 2

FIGURE 3

Page 1




TECH. I
TECH. II
TECH. III
TECH. IV
TECH.V
TECH. VI
SPEC. I
SPEC. II
SPEC. III
V A Ordering & storing Forms & Supplies
VI A Simple Ward Admissions
XIII B Conducting Activities
XIV B Nursing Treatments
XIV D Ordering & Administering Meds
XIII C Organizing Activities
XIV C Nursing Administration
XVI B Intermediate First Aid
III E Dissemination of Information
IV A Shift Task Performance
IV B Dealing with Staff
VI B Initial Casework
VI C Treatment Planning
VI C-1 Documentation
VI E Resident's Social & Personal Needs
VI I Interviewing


TECH. I
TECH. II
TECH. III
TECH. IV
TECH.V
TECH. VI
SPEC. I
SPEC. II
SPEC. III
VI J Dealing With Friends & Relatives
XIII A Ordering Supplies for Ward Commissary
III A Ward Coverage & Resource Allocation
III D Providing for Employee Training
VI F Discharge Planning
IV B Dealing with Staff & Superiors on Performance, Promotions & Discipline
III C Dealing with Staff & Superiors on Performance, Promotions & Discipline
III F Teamwork Competencies
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